No. 82-1760

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

HEALTH CARE PLAN OF NEW JERSEY, INC., a federally qualified health maintenance organization,

Petitioner,

v.

MARGARET M. HECKLER, Secretary, United States Department of Health & Human Services; J. RICHARD GOLDSTEIN, Commissioner, New Jersey Department of Health; New Jersey Hospital Rate Setting Commission,

Respondents.

BRIEF FOR RESPONDENTS J. RICHARD GOLDSTEIN, COMMISSIONER OF HEALTH AND NEW JERSEY HOSPITAL RATE SETTING COMMISSION OPPOSING PETITION FOR CERTIORARI

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BRIEF FOR RESPONDENTS J. RICHARD GOLDSTEIN, COMMISSIONER OF HEALTH AND NEW JERSEY HOSPITAL RATE SETTING COMMISSION OPPOSING PETITION FOR CERTIORARI

Counter-Statement of the Case

This case was brought by one health maintenance organization in New Jersey challenging a system for setting uniform rates for hospital charges reimburseable by all users and payers of hospital services in the State. The chal-

lenge rested on the claim that the system increased the amount which the petitioner had to pay for hospital services for its subscribers and otherwise interfered with its operation as a federally qualified health maintenance organization under the federal Health Maintenance Organization Act, 42 U.S.C. §300e *et seq.* The United States District Court for the District of New Jersey, in a decision reported at 553 F.Supp. 440 (D. N.J. 1982) (Pa3 to Pa35), found no impediment under the Supremacy Clause to the application of New Jersey's hospital rate-setting system with respect to the rates payable for hospital services by the health maintenance organization. This decision was affirmed by a judgment of the Third Circuit Court of Appeals entered on January 6, 1983 (Pa1 to Pa2), which the petitioner now seeks a writ of certiorari to review.

The case arose under relatively novel circumstances, particularly since New Jersey's system of hospital rate-setting was itself an innovative program in the field. The legal issues, however, not only have been correctly decided by the lower federal courts but are of such uncommonly limited import as to warrant denial of the writ of *certiorari.*

By amendments to New Jersey statute passed in 1978, the New Jersey Department of Health was authorized to administer a comprehensive system for setting hospital rates of reimbursement applicable to all persons and entities paying for hospital services. N.J.S.A. 26:2H-1 *et seq.*, as amended by L.1978, c. 83. A hospital rate review program had previously been in existence for several years, but it was applicable to rates payable by only two classes of payers, namely Blue Cross and State government agencies. N.J.S.A. 26:2H-18, as enacted by L.1971, c. 136. The 1978 amendments were designed to address a number of problems in the costs and delivery of hospital care in the State which had been ineffectively controlled

by the previous rate program. For example, the substantial financial burden of inner-city hospitals, faced with growing debts from serving uninsured medically indigent patients, was intended to be alleviated by guaranteeing incorporation in the rates of certain financial elements not theretofore recognized under the rate review program. However, the legislative amendments also strengthened the State's policy of maintaining efforts to contain the escalation of hospital costs by making the hospital rate-setting system uniformly applicable to all payers, in order to assure that hospitals could not avoid the effect of rate review by shifting their unapproved costs to various classes of payers. In this regard, the New Jersey statute provided that payment rates for all purchasers of hospital services ". . . shall be equitable for each payer without discrimination or individual preference," except that payer differentials could be granted by the New Jersey Hospital Rate Setting Commission based on ". . . quantifiable economic benefits rendered [by the payer] to the institution or to the health care delivery system taken as a whole." N.J.S.A. 26:2H-18(b).

Acting pursuant to this legislative authority, the New Jersey Department of Health initiated a regulatory program (N.J.A.C. 8:31B-3.1 *et seq.*), applied gradually to groups of hospitals beginning in 1980, which employed a rate-setting method of departing from the traditional basis of *per diem* payments. Proceeding on the concept that utilization of hospital resources varies according to the complexity and types of cases treated rather than the number of days a patient remains in the facility, payment rates were figured for 383 "Diagnosis Related Groups" (DRGs). The payment rate for each DRG, incorporating all required financial elements, is set prospectively, in advance of the rate year, and generally remains a fixed, flat fee, irrespective of the patient's length of stay in the hospital. The prospective and fixed nature of the DRG rate was

intended to furnish financial incentives for hospitals to provide appropriate treatment with increased efficiency, for if a patient could be medically discharged at an early time without expending all the costs included in the particular DRG rate, the hospital could nevertheless charge the full DRG rate. At the same time, the hospital confronted the risk of a financial loss if its costs exceeded the DRG rate, thereby experiencing a financial disincentive for inappropriate, uneconomical services.

Because of its interest in experimental rate-setting programs for purposes of hospital cost containment, the United States Department of Health and Human Services funded the development of the DRG system. Further, pursuant to 42 U.S.C. §1395b-1(b), the Secretary of Health and Human Services granted a waiver of standard principles of reimbursement for the federal Medicare program (Title XVIII of the Social Security Act, 42 U.S.C. §§1395 *et seq.*), so that payment of hospital services for Medicare beneficiaries in New Jersey is being made at the DRG rates set by the New Jersey Department of Health (2T73-20 to 2T75-8, 2T85-3 to 18).*

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* As the petitioner has noted, the use of prospectively determined rates classified by Diagnosis Related Groups has now been selected for Medicare payments for inpatient hospital services on a national basis, effective October 1, 1983, as provided by the very recent Social Security Act Amendments of 1983, *Pub. L. No.* 98-21, Title VI, §§601-607. Those Amendments also contain provisions reflecting the fact the Medicare currently participates in demonstration projects for hospital rates in four States, namely, Maryland, New Jersey, New York and Massachusetts. The provisions permit the Secretary of Health and Human Services to continue participation in a State program like New Jersey's operating under a current Medicare waiver, upon the State program's compliance with certain conditions, including the condition that a health maintenance organization may nego-

(Footnote continued on following page)

When, in May 1981, one of its contracting hospitals became subject to the State's regulatory system and began billing at the DRG rates, the petitioner instituted suit in the United States District Court to enjoin the application of the setting system to the hospital rates it was obliged to pay. It claimed that as a federally-qualified health maintenance organization it should be exempt from furnishing the hospital payment rate set by the State's system and instead be left free to negotiate payment rates directly with the hospitals. Such exemption was premised on the ground that the State's rate-setting system conflicted with the federal Health Maintenance Organization Act, 42 U.S.C. §§300e *et seq.* and the National Health Planning Resources and Development Act, 42 U.S.C. §§300k *et seq.** A health maintenance organization essentially

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tiate directly with hospitals regarding payment for inpatient hospital services. *Pub. L. No.* 98-21, §601(c)(3), see *H.R. Rep. No.* 98-47, 98th Cong. 1st Sess. published at *Cong. Rec.* H1724, H1777 (daily ed. March 24, 1983). Extensive efforts had been made by New Jersey to secure the Medicare waiver in the past. Indeed, when enacting the 1978 amendments to the State statute, the New Jersey Legislature clearly intended to frame the legislation in a manner enabling the approval of a Medicare waiver. See *Statement of New Jersey Senate Institutions, Health and Welfare Comm. to S. Bill No.* 446, p.2 (Df. Ex. 1). Accordingly, it may reasonably be expected that the State will undertake all action necessary to maintain continuance of Medicare participation in its program under the conditions prescribed by the Secretary.

* It should be noted that the Secretary of Health and Human Services who is responsible for administering both the federal Health Maintenance Organization Act and the National Health Planning Resources and Development Act, was named as a party to the suit. At no time did the Secretary indicate agreement with the legal position asserted by the petitioner, but rather concurred with the State defendants and joined them in opposing the granting of any relief on the complaint.

combines the delivery and financing of health care in one organized system. It provides a range of health services to voluntarily enrolled members in return for a fixed, prepaid fee. The fee covers services in the health maintenance organization's own facilities as well as in a hospital which the organization contracts for treatment of its enrollees. See *S. Rep. No.* 93-129, 93d Cong. 1st Sess. (1973), [1973] vol. 2 *U.S. Code Cong. & Adm. News,* 3033, 3034, 3039-3040; see also Pl. Ex. 1, p. 1. Federal approval is not required for any health maintenance organization. However, a health maintenance organization which meets the qualifications of the federal Health Maintenance Organization Act is eligible for federal grants, loans and loan guarantees for its initial operations. 42 U.S.C. §§300e-8. The federal Act additionally requires most employees to offer their employees the choice of traditional health benefit insurance or coverage through a federally qualified health maintenance organization. 42 U.S.C. §300e-9. Federally qualified organizations remain subject to continuing supervision by the Secretary of Health and Human Services and may lose their qualification if found to be out of compliance with the Act's standards. 42 U.S.C. §300e-11.

At the time suit was instituted the petitioner had received $1.6 million in grants and $3.1 million in loans from the Secretary of Health and Human Services under the federal Health Maintenance Organization Act (Pa9). Its status as a federally qualified health maintenance organization was in jeopardy at the time because of warnings regarding its fiscal condition which it had received from the Secretary in April 1980, long before encountering the rates set by the New Jersey system (Pa18 to Pa20). With the imposition of the DRG system, its hospital bills for the first few months' experience were 10% higher than petitioner had anticipted or would have paid under its prior *per diem* contract with the hospital (Pa17 to Pa18).

Besides these financial effects, the petitioner alleged that the DRG system was destroying its ability to function effectively as a health maintenance organization. Since it no longer paid for hospital services on a *per diem* basis, its physicians did not have financial incentives to discharge petitioner's subscribers as quickly as possible in order to reduce hospital bills (Pa16).

After trial on the matter, the United States District Court concluded that the application of the DRG system had not been preempted by the federal Health Maintenance Organization Act. It was recognized that Congress undoubtedly intended to promote the development of health maintenance organizations as one means of enhancing opportunities for decent health care at a reasonable price (Pa28). In this regard, several provisions of the federal Health Maintenance Organization Act explicitly prohibited states from placing certain types of restrictions upon the formation, organization and advertising of health maintenance organizations. 42 U.S.C. §§300e-10, 300e-11. These provisions, however, were regarded by the District Court as setting health maintenance organizations on an equal footing with other providers of health care. No Congressional intent could reasonably be discerned for placing health maintenance organizations at a special and distinct advantage over other providers and insurers in the medical marketplace (Pa31 to Pa32).

The Court further noted that the petitioner's financial difficulties could not fairly be attributed to the displacement of its *per diem* contracts by the DRG system but rather stemmed in large part from the petitioner's own misforecasts in its financial planning (Pa17 to Pa18, Pa30). While the DRG system did decrease the financial incentives for the petitioner and its physicians to discharge hospital patients as promptly as medically sound, the finan-

cial incentives to shorten hospital stays remained but had been shifted by the DRG system to the hospitals themselves. Nevertheless, the diminution in financial incentives for the petitioner did not seriously undermine its functional capacity. Because of its operational characteristics, its emphasis on preventive health care and its use of preadmission testing, the petitioner as a health maintenance organization retained its unique position to minimize costs to its members (Pa31). Thus the District Court could find no conflict between the provisions and objectives of the federal Health Maintenance Organization Act and the application of the State's rate-setting system to hospital rates payable by all recipients of hospital services, including a health maintenance organization. The Court also rejected petitioner's reliance on the National Health Planning and Resources Development Act, 42 U.S.C. §300k *et seq.* Inasmuch as that Act concerned the review of federal financial assistance for plans for new capital expenditures by health care facilities and for the initiation of new health care services, none of which was directly at issue in the case, the Court rejected the relevance of that Act and petitioner's standing to raise any of its provisions (Pa33 to Pa34).

The District Court's judgment was affirmed on appeal by the United States Court of Appeals for the Third Circuit on January 6, 1983 (Pa1 to Pa2). A Petition for Rehearing was denied by the Third Circuit in an Order entered on January 31, 1983 (Pa36 to Pa37). The instant Petition for Writ of *Certiorari* was filed on April 28, 1983.

ARGUMENT

The United States Court of Appeals properly affirmed the decision of the District Court holding that New Jersey's system setting hospital rates of reimbursement payable by all purchasers of hospital services was not partially preempted by the Federal Health Maintenance Act with respect to hospital rates payable by a health maintenance organization, and no issue of public importance having been presented, the petition for certiorari should be dismissed by this Court.

Since the analysis of any issue of federal preemption ". . . turns on the peculiarities and special features" of each case in question, *City of Burbank* v. *Lockheed Air Terminal, Inc.*, 411 U.S. 624, 638 (1973), some significance beyond the confines of the specific case itself should appear before this Court's attention is engrossed in the particularities and before a writ of *certiorari* would be appropriate. The peculiar circumstances of one health maintenance organization under a State's experimental program to grapple with the perplexing dynamics of containing hospital rates simply do not present a matter of sufficient moment to warrant review by this Court. The recent changes introduced by the Social Security Act Amendments of 1983, which contain provisions specifically directed to the question presented here (see *infra*, fn. on page 4) further undercut the lasting significance of any decision on the merits. For all practical purposes, the question of the petitioner's relationship to New Jersey's hospital rate-setting program has been of isolated and transitory importance.

Contrary to petitioner's exaggerations (Pb55), all health maintenance organizations will hardly be affected by a

construction of the application of a rate program operative only in New Jersey. Indeed, not even all health maintenance organizations in New Jersey would be affected, for several of them are not federally qualified under the Act which serves as the fulcrum of analysis of the preemption question. Of the nine health maintenance organizations operating in New Jersey in July 1981, three were not federally qualified (see Pb17, fn. 4). Moreover, in marshalling the evidence for its claims, the petitioner relied heavily on the terms of a Corrective Action Plan issued by the Secretary of Health and Human Services in June 1980 which exhorted the petitioner to negotiate *per diem* rates with its contracting hospitals (Pl. Ex. 4). Petitioner continues to stress this Corrective Action Plan, likening it to an administrative regulation and contending that it shows a federal mandate that *per diem* rather than DRG rates be used for payment of hospital services (Pb20 to Pb21, Pb42 to Pb43). Yet, no other health maintenance organization in the State was shown to be subject to a similar direction, not by means of any other Corrective Action Plan, or by duly promulgated regulation or by any provisions in the federal Health Maintenance Organization Act. In truth, the Corrective Action Plan was a set of remedial measures submitted by the petitioner itself, and thereafter approved by the Secretary, addressed to the petitioner's own particular difficulties (Pl. Ex. 4). Furthermore, even more significantly in terms of the merits of the legal issue, the Corrective Action Plan was provided at a time (June 1980) when the *per diem* contracts had not yet been affected by application of the new DRG rate-setting system (implementated with respect to the petitioner in May 1981). Rationally construed against the background of the then-existing State law, the petitioner's Corrective Action Plan, tailored to its individualized situation, quite clearly falls short of constituting a uniform

rule by the federal administrator mandating *per diem* hospital rates on a universal basis.*

Nor did any other piece of evidence or legal argument of the petitioner satisfy the standards for finding federal preemption in the absence of an express preemptive clause in the federal Health Maintentance Act. As the District Court noted (Pa32), Congressional intent to preempt State laws in fields historically occupied by the states is not to be lightly inferred and should not be found unless manifestly and unmistakably so ordained. *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981); *Exxon Corp.* v. *Maryland*, 437 U.S. 117, 132 (1978); *Jones* v. *Rath Packing Co.*, 430 U.S. 519, 525 (1977); *Florida Lime & Avocado Growers, Inc.* v. *Paul*, 373 U.S. 132, 142 (1963). The District Court carefully scoured the provisions, legislative history and intent of the Health Maintenance Organization Act. It found evident, in 42 U.S.C. §300e-10, Congressional intent to relieve health maintenance organizations from State laws unduly burdening their formation (Pa21 to Pa24).** However, it could not find, nor could it it be found,

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* Following the conclusion of this case in the United States District Court, the Secretary, in January 1982, restored the petitioner to compliance status (Pb21), even though its contracting hospital was billing at DRG rather than *per diem* rates at that time. It therefore seems apparent that the terms of the Corrective Action Plan relating to the use of *per diem* contracts were understood by the Secretary to be applicable only insofar as permitted by State law.

** The statutory provision, quoted in its entirety at Pa22 to Pa24, enumerates five types of State laws which were expressly superceded by 42 U.S.C. §300e-10, namely those that: 1) require approval by a medical society before a health maintenance organization may do business in the State, 2) require that physicians comprise part of the governing body of the health maintenance organization; 3) require that a percentage of physicians partici-

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that Congress ever intended to immunize health maintenance organizations from every State law which may affect them or to confer them with positive competitive advantages over other purchasers of medical services (Pa31 to Pa32). On the contrary, the manifest intent, as revealed by the legislative history, was to neutralize onerous State laws directed specifically at restricting health maintenance organizations and to ". . . ensure an *equal* opportunity in all states for development of HMOs . . ." *S. Rep. No.* 93-129, 93rd Cong., 1st sess., [1973] vol. 2, *U.S. Code Cong. and Adm. News,* 3033, 3060 (Emphasis supplied).

Thus, the lower court's holding that the federal Health Maintenance Act did not partially preclude New Jersey from exercising its traditional police power to implement a comprehensive hospital rate-setting scheme that applies equally to all payers of hospital services is eminently sound. The incidental adverse financial effect of the DRG rates, leading to bills 10% higher than petitioner expected (Pa17), in itself does not suffice to establish any conflict with the federal legislation.* See *Exxon Corp.* v. *Maryland, supra,* 437 U.S. at 133. Furthermore, the "admissions" of the New Jersey Department of Health, upon which petitioner places great emphasis (Pb13 to Pb15,

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pate in the reorganization; 4) impose stringent initial capitalization and financial reserve provisions and 5) prevent health maintenance organizations from soliciting members through advertising.

* An avenue of relieving economic hardship was made specifically available for health maintenance organizations by administrative appeal to the New Jersey Hospital Rate Setting Commission (Pl. Ex. 9). Despite the willingness of the Commission to entertain applications for such relief, no health maintenance organization submitted a request on that basis (2T102-21 to 2T103-24). The petitioner is thus in error in stating that no relief was afforded health maintenance organizations for their cash flow problems (Pb15 to Pb16); more accurately, none was ever sought by them.

Pb34 to Pb35) are merely sympathetic reflections of the opinions related to the Department of Health by health maintenance organizations themselves. When put to its proof, however, the petitioner notably failed to support the conclusory statements that the DRG hospital rate system produced any "drastic" or "dramatic" disruption of any health maintenance organization's fundamental operations. It has also failed to prove to any court thus far that through the federal Health Maintenance Act Congress intended to shield the petitioner from a uniform State law prescribing the rates chargeable by hospitals to all who use hospital services any more than it intended to exempt petitioner or any other health maintenance organization from State law setting the retail rates for water, electricity or utilities supplied to the organization's offices and facilities. *See Arkansas Elec. Coop. Corp.* v. *Arkansas Pub. Comm'n,* 51 U.S.L.W. 4539 (U.S. May 16, 1983).

The relevance of the additional national Health Planning Resources and Development Act, 42 U.S.C. §300k *et seq.* to the issues in this case is imperceptible. That Act provides for federal financial assistance to States which establish a program of health planning by enactment of certificates of need laws to review capital expenditures and new health services proposed by health care facilities. 42 U.S.C. §300m-2(a)(4)(B). See *North Carolina* v. *Califano,* 445 F.Supp. 532, 534 (D. No. Car. 1977), *aff'd,* 433 U.S. 962 (1978). Proposals for the use of federal funds available under Acts specified in 42 U.S.C. §300l-2(e) are also subject to review by State and local health planning agencies. The petitioner had not proposed a service for which a certificate of need was required; it also had no pending application for funding to be reviewed under the criteria mentioned in that Act. The District Court accordingly could not divine

how that particular Act, which relates to an entirely different field of endeavor, was germane to the issues presented in the context of hospital rate-setting (Pa33 to Pa34). Its pertinence continues to be elusive; certainly the argument of the petitioner cannot reasonably be bolstered by reference to shreds of legal provisions in an Act whose relevance to the issue is most dubious.

In sum this matter is neither of sufficient legal merit nor public importance to commend a writ of *certiorari* by this Court. The issue of federal preemption was properly decided by the lower federal courts in this case which, in any event, is of such singularly narrow impact and focused on limited circumstances, highly subject to probable change, as to require no further consideration.

CONCLUSION

For these reasons it is respectfully submitted that the petition for a writ of *certiorari* should be denied.

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DATED: May 26, 1983